STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXXXXXXXXXXXXXX

Petitioner **File No. 53740-001**

v.

Respondent

Health Alliance Plan of Michigan.
_____/

Issued and entered
this 13th day of June 2003
by Linda A. Watters
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 29, 2003,XXXXXXXXXXX (Petitioner), filed a request for external review with the Commissioner of the Office of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. After an assessment of the material submitted, the Commissioner accepted the request.

The issue in this matter is contractual. There is no medical issue. Therefore, review by an independent review organization (IRO) is not required. The Commissioner reviews contractual issues under MCL 500.1911(7). On May 15, 2002, the Office of Financial and Insurance Services (OFIS) received the information Health Alliance Plan (HAP) used to make its adverse determination in Petitioner's case.

II
FACTUAL BACKGROUND

Petitioner is a Health Alliance Plan (HAP) member. Her medical benefits are being coordinated with her XXXXXX car insurance benefits. Petitioner is seeking reimbursement for services related to an XXXXXXXXXX, auto accident received from non-affiliated providers. She is also seeking a refund of the premiums she paid for COBRA from XXXXXXXXXX through XXXXXXXXXXXX. The refund of COBRA premiums will not be discussed in this order because the Patients Right to Independent Review only applies to health care services that have been denied, reduced or terminated.

Petitioner is a XXXXXXXXXXXXXXXX for the XXXXXXXXXXXXXXXXXXXX. On XXXXXXXXXX, her right knee was fractured in a car accident. The knee did not heal properly. She had a 15° contracture in her right knee. She saw Dr. XXXX, a HAP affiliated orthopedic surgeon. He did not recommend a partial patellectomy. He prescribed a Dyna splint and a bone stimulator to improve her extension. Dr. XXXX wanted Petitioner to continue physical therapy. Then manipulation under anaesthesia would be considered. Petitioner disagreed with his prescribed course of treatment. She tried to work with her primary care physician (PCP) but was unsuccessful.

When her knee did not respond to physical therapy, she decided to aggressively pursue treatment. The 15° contracture was now a 30° contracture. Over the next several months, without referrals from her PCP, Petitioner obtained second opinions from three non-affiliated providers. The three non-affiliated providers recommended arthroscopic surgery. Petitioner contends her affiliated surgeon did not agree with the other physicians' diagnoses or proposed treatment plans. She received physical therapy from an out-of-plan center. After a grievance, these therapy visits were approved by HAP. According to a XXXXXXXXXXXX, medical report from Dr. XXXXXXXXX, the therapy straightened the contracture. The Petitioner fell and

re-injured her knee in XXXXXXXX. On the recommendation of her auto insurance caseworker she went to a physiatrist who recommended therapy and suggested exercises.

On XXXXXXXXXXXXX, Petitioner filed a grievance to request a different affiliated surgeon. HAP denied a referral to the orthopedic surgeon Petitioner selected, but approved a referral to Dr. XXXXXX. She declined this referral based upon the advice from her PCP, one of the non-affiliated surgeons, and her auto insurance case manager and elected to see Dr. XXXXXXXX, one of Dr. XXXXXX associates. The earliest appointment she could get was 3 months away. On XXXXXXXXXXXXX, she saw Dr. XXXXXXXX who recommended an examination under general anesthesia and arthroscopic surgery. She suspected scar tissue was interfering with Petitioner's range of motion. On XXXXXXXXXXX, Dr. XXXXXXXX performed the examination and arthroscopic surgery and recommended physical therapy.

On XXXXXXXXXXX, Petitioner again sought treatment from a non-affiliated provider because she was having difficulty and pain while standing. She was having difficulty and pain walking and moving. Petitioner continued to experience pain over the next several months that she believed her surgeon and PCP were not addressing. She tried unsuccessfully for several months to determine the source of her pain utilizing affiliated providers including her PCP and new surgeon. Petitioner states that after several attempts to control her pain with no results, she again sought treatment from non-affiliated providers. She saw a podatrist and a chiropractor. The chiropractor told her she had a systemic problem that needed more tests and treatment.

After blood tests her PCP informed her she had rheumatoid arthritis and referred her to a rheumatologist. Petitioner wanted a second opinion and again went to a non-affiliated provider. The non-affiliated provider disagreed with the affiliated providers' treatment plan. Petitioner was allowed to continue treatment with the non-affiliated provider.

Petitioner believes the whole ordeal of trying to obtain an accurate medical diagnosis

caused her: 1) considerable stress and suffering, resulting in the need for counseling and Rolfing (integrated muscle therapy), and 2) considerable costs to seek treatment from non-affiliated providers. On XXXXXXXXXXXX Dr. XXXX suggested a psychiatric consultation. Petitioner had seen XXXXXXXXX, MSW, ACSW, a non-affiliated provider, 11 times in XXXX, 43 times in XXXXX and 31 times in XXXXXfor anxiety disorder due to difficulties obtaining accurate medical diagnosis and treatment.

HAP denied the request for reimbursement because:

- Services were obtained from non-participating providers without referral authorization
- Rolfing is not covered by HAP
- Chiropractic services are not covered by HAP

Petitioner exhausted HAP's internal grievance process and received its final adverse determination in this matter in a letter dated March 10, 2003.

III
ISSUES

Did Health Alliance Plan of Michigan appropriately deny coverage for: 1) services obtained without a referral from non-affiliated providers, 2) Rolfing, and 3) chiropractic services?

IV
ANALYSIS

Petitioner's Argument

Petitioner tried to utilize affiliated providers to obtain relief from problems associated with a car accident. After several unsuccessful attempts, she referred herself for second opinions with other treatment sources that were non-affiliated to seek of relief from the pain and anxiety she was experiencing. She took this action because she believed HAP was preventing her from getting treatment in a timely manner.

Petitioner states her injury took 5 weeks to heal but it took fourteen months to receive proper treatment. She received proper treatment because she took matters into her own hands and sought non-affiliated treatment. She believes HAP's inadequate, inappropriate and

untimely treatment of her fractured knee forced her to seek services from non-affiliated providers. HAP should allow retro-authorization and coverage for the services associated with consultations and treatment she received from non-affiliated providers.

HAP's Argument

In its March 10, 2003, final adverse determination letter, HAP states it denied coverage for the services and premiums because:

- They were obtained from non-affiliated providers, providers outside of her assigned network without referral authorization and were available within the HAP network of providers
- Structural integration therapy is a non-covered benefit of her contract
- Chiropractic services are non-covered benefits of her contract
- Mental health visits from a non-affiliated provider exceeded the maximum number of 20 per calendar year allowed by her contract.

In support of their argument, HAP refers to section V. of Petitioner's HMO Certificate of Coverage, which states in pertinent part:

> **Section V. Member's Rights and responsibilities**
>
> H. Medical care for non-urgent and non-emergent medical conditions shall become the responsibility of Health Alliance Plan only upon written referral from an Affiliated Provider Physician according to Health Alliance Plan's accepted referral and practice policies. A Member must obtain prior written authorization on a completed Health Alliance plan referral form for all such referrals by an Affiliated Provider Physician indicating a designated provider. A Member who wishes to obtain additional information regarding the accepted referral and practice policies may do so by contacting Health Alliance Plan's member Services Department with regard to his/her specific needs.
>
> K. A Member has the option of obtaining a second physician's opinion from an Affiliated Provider Physician within his/her assigned network on the propriety of any diagnosis or recommended medical procedure. To obtain a second opinion, a Member must have a written referral from his/her primary Care Physician to another Affiliate Provider Physician.

HAP denies the services lacked quality of care. Quality care was readily available to the Petitioner from HAP providers from XXXXXXXXX, through the summer of XXXX. Petitioner eventually underwent treatment in XXXXXXXXXX that was recommended by her HAP provider in XXXXXXXXXXXX. HAP contends it was "Petitioner's uncertainty regarding which treatment plan to accept that contributed to the length of time it took to receive services.

Commissioner's Review

The Commissioner carefully reviewed the arguments and documents presented by the parties in this case. The focus of this analysis is whether under its Certificate of Coverage (Certificate) HAP properly denied Petitioner retro-authorization and coverage for medical services obtained from non-affiliated providers, chiropractic, and structural integration services. The HAP Certificate requires health services to be provided by or under the direction of the PCP, except in emergency or urgent care situations outside of the service area, or for referral services authorized in advance by HAP. HAP is a Health Maintenance Organization (HMO). HMO's contain costs by using a network of providers. It is reasonable for a HMO to require its members to consult with affiliated providers before utilizing non-affiliated providers.

According to HAP's Certificate, there are specific procedures to be followed to obtain a referral for non-affiliated services. If authorization for a service is not obtained prior to the services being rendered, the services are excluded under the contract. On several occasions, between, XXXXXXXXXX, and XXXXXXXXX, without HAP approval, Petitioner received treatment from non-affiliated providers, or non-covered services. All of the treatment that is in question did not have plan approval. The services were received prior to HAP receiving the request for the services. HAP did not have an opportunity to determine whether the services would be covered. The Petitioner did not have authorization to obtain the out-of-network services she received.

After due consideration of all the materials presented, the Commissioner finds that the services provided to Petitioner by the various non-affiliated providers were properly denied by HAP. There are several reasons for this conclusion. First of all, affiliated providers can provide second opinions and arthroscopic procedures. Secondly, there is no documentation the PCP attempted to obtain authorization to refer the Petitioner for non-affiliated services. The Petitioner received treatment from non-affiliated providers without authorization. Therefore, the Commissioner finds, HAP's determination in this matter is valid. Petitioner is not entitled to retro-authorization and coverage for the care she received from non-affiliated providers. Several of the services the Petitioner received, chiropractic and Rolfing are not covered benefits under the Certificate. HAP properly denied coverage for those services.

V
ORDER

The Commissioner upholds HAP's, March 10, 2003, final adverse determination in Petitioner's case. HAP properly denied Petitioner retro-authorization and coverage for services received from non-affiliated providers and properly denied payment for non-covered services.

This is a final decision of an administrative agency. Under MCL 550, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Linda A. Watters
Commissioner